

POSTGRADUATE NURSING PROGRAMME CLAIM FORM

CHECK LIST

(Please provide receipts and claim cost **up to** the amount recorded in the trainee's contract)

Attach: Copy of results GST receipts Organisations GST invoice for costs (external only)

Send to: PG Nursing Coordinator
 Email: PGNursing@northlanddhb.org.nz
 Post Rm 43, Nursing & Midwifery Directorate, Maunu House
 Te Whatu Ora Tai Tokerau, Private Bag 9742, Whangarei 0148

STAFF INFORMATION	
Staff Members Name:	
Name of Organisation:	
Course/ Papers completed:	
Semester and year:	

STUDY LEAVE/SUPERVISION COSTS	
Study leave costs	\$
Clinical supervision: eg. prescribing practicum	\$
ACCOMMODATION	
Accommodation (attach GST receipts)	\$
TRAVEL COSTS	
Te Whatu Ora car utilised? (<i>Te Whatu Ora Staff only</i>)	Yes / No
Total km travelled (<i>use box pg 2</i>)	km
Total mileage reimbursement (<i>use box pg 2</i>) @/ km	\$
Extra travel costs (other than mileage, attach GST receipts)	\$
TOTAL CLAIM (attach proof of pass)	\$

I confirm that (staff member) attended the associated study days.

Line Manager Signature: Date:

PRIVATE/WORK VEHICLE USE TABLE

NB: Te Whatu Ora Staff can claim 20c/km plus \$4 per hour
External organisations as per organisational policy

DATE TRAVELLED	FROM / TO	TIME TRAVELLED	NO. OF KM TRAVELLED
TOTALS			

OFFICE USE ONLY

COST CODE	AMOUNT REIMBURSED
5015215-2205-00071 (fees)	\$
5015215-2205-00071 (study/sup)	\$
5015215-2205-00071 (travel/accom)	\$
GST	\$
Total	\$

AUTHORISATION

Nurse Coordinator: Post Graduate Education Signature	Date
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Chief Nursing Officer Signature	Date
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Business Analyst Signature	Date
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STAFF EXPENSES AND CME REIMBURSEMENT FORM

Name _____ Department _____
 Employee No. _____ W R Ext. _____ Cost Code 5015215-2205-00071
 Course/Meeting: _____

PROVIDE DESCRIPTION FOR ITEMS CLAIMED	Gross Claim \$	Payroll Element		
Course fees, Conferences and Study Grants (suffix 00072)		CME Y=C	HWF Y=H	GST N=X
Courses/Conferences Fees:		RCON		G
Accommodation:		RACOM		G
Travel:		RTRAV		G
Course Materials:		RCMAT		G
Meals:		RMEAL		G
Tertiary Study/Training Fees:		RTSTUD		G
Technology:		RTECH		G
Journals and Texts:		RJNL		G
Business Expenses (meetings etc)				
Accommodation: (5260)		RACOM B		G
Travel: (5250/5255)		RTRAV B		G
Meals: (5260)		RMEAL B		G
Professional Membership Fees and Costs (suffix 00076)				
Membership Fees/Subscriptions:		RMFEE		G
Practice Insurance Premiums:		RINS		G
Annual Practicing Certificates:		RPRAC		G
Other (relocation, uniforms, telephone etc)				
Details:				G
				G
				G
Checklist		Total Claim \$NZ		
<input type="checkbox"/> I have attached original receipts for all claims		Other Currency \$		
<input type="checkbox"/> I have attached original tax invoices for all claims over \$50				
<input type="checkbox"/> I understand that EFTPOS dockets are insufficient				
<input type="checkbox"/> I have attached documentation for any courses				

SOMOs: I declare that my only income from Medical Practice is derived from employment by Northland District Health Board. **Signature :** _____ **Date** / /

Claimants Signature: _____ Date / /
 Controlling Officer: _____ PG Ed Coordinator Date / /
Signature name
 Business Analyst: _____ Business Analyst Date / /
Signature name
 General Manager: _____ Chief Nursing Officer Date / /
Signature name

Is this a CME (Continuing Medical Education) claim? Yes No _____ % MSU: _____
 Is this a HWF (Health Work Force - CTA) claim? Yes No

Expenses cannot be reimbursed unless this form is completed, authorised and appropriate documentation attached. This reimbursement will be direct credited to your payroll bank account. **Once authorised by appropriate delegated authority please forward to Kathy Crawford, Finance Dept, 1st floor, Dairy House. Please ring ext 7967 with any queries.**
 (Version 18)